Executive Office of Health and Human Services

Rhode Island Medicaid Reform

Joint Meeting
House Committee on Finance
Senate Committee on Finance
August 5, 2008

Rhode Island Medicaid Reform

Three Major Components of Medicaid Reform:

- Rebalance Long Term Care system
- Manage care across all Medicaid populations
- Complete transition from payor to purchaser for all Medicaid populations

The Global Waiver provides certain tools to accomplish Medicaid reform:

- Aggregate allotment of federal funds
- Flexibility on federal Medicaid rules

Medicaid Reform: Component One

Rebalance Long Term Care (LTC) system

Enhance access and availability of LTC services in most appropriate settings (home, shared living & assisted living) as alternative to more restrictive settings (e.g. nursing homes & residential care)

Actions needed:

- Streamline process to assess, refer, and assist consumers to choose the most appropriate LTC services in least restrictive setting
- Develop and enhance community service capacity, which includes shared living, assisted living, and in-home services
- Develop payment methodologies which provide incentives to rebalance the delivery system in favor of home and community-based care

Medicaid Reform: Component Two

Manage care across all Medicaid populations

- Require all Medicaid beneficiaries to participate in a managed care program*
- Build on RIte Care, ConnectCare Choice (PCCM), PACE, and Rhody Health Partners to ensure coordinated and accessible care management for all Medicaid enrollees
- Establish Healthy Choice Accounts (HCA) that reward wellness, prevention and healthy lifestyles

*Note: Persons with existing third party comprehensive medical coverage will be exempted from this requirement. For example, the successful RIte Share premium assistance program will continue, and dual Medicare/Medicaid eligibiles will continue to receive acute health services from Medicare.

Medicaid Reform: Component Three

Complete the transition from payor to purchaser for all Medicaid populations

- Tie reimbursement to performance and quality of care
- Purchase selected health care services interdepartmentally
- Enhance competition to assure capacity to provide the most appropriate services and settings at the best price

Global Waiver:
One Tool for Medicaid Reform

- Financing Structure
- Federal Flexibility

Global Waiver: Financing Structure

- Fundamentally restructure the State Medicaid program from a traditional open-ended entitlement program to one based on:
  - Defined State commitment
  - Defined/fixed Federal contribution
- Combined funding will require significant restructuring and rebalancing of program.
  - If granted, maintain federal level of funding for Waiver period to permit program restructuring
- Total funds available for Medicaid will equal the sum of these two:
  - Defined federal contribution + state contribution
- Waiver agreement with CMS will specifically and separately define these contributions

Financial Commitments: Federal Commitment

Proposal requests a specific level of federal contribution

- Based on SFY 2002-2007 RI Medicaid expenditure experience forecasted for the Waiver period, with certain adjustments (e.g. Medicare Part D drug coverage, increases in persons over 65, SCHIP financing changes, etc)
  - Projects an aggregate annual trend of 9.2%
    - 6.8% in per member per month (PMPM) annually
    - 2.3% annual growth in number of eligibles
- Seeks defined federal financial share during the waiver period based on the "without Waiver" expenditure forecast

Defined Federal Contribution

How Did We Derive the Requested Federal Budget?

Step 1: Examined 2002-2007 spending and PMPMs

Added in off-line expenditures (not in MMIS)

Excluded DSH, LEA, Admin

Included SCHIP costs to recognize SCHIP funding limits, people/costs shifted to Medicaid

Backed out Rx shifted to Medicare Part D

Adjusted for data anomalies

Step 2: After adjustments, calculated average annual percent change in caseload, PMPMs

Step 3: To trend 2007 forward, used historic trends adjusted for increased costs due to aging of population and rising unemployment.

Step 4: Applied estimated FMAP percentage to trended amount over five year period to derive requested federal amount

What is the forecasted "without waiver" expenditure for the five year waiver period?

Basis for determining the Federal contribution

Expenditure forecast submitted to CMS

		BASE YR							
	Trend	FFY07	FFY08	FFY09	FFY10	FFY11	FFY12	FFY13	5 Yr Cap
$	**9.2%**	**1,721**	**1,892**	**2,074**	**2,257**	**2,454**	**2,677**	**2,924**	**$ 12,386**
PMPM	6.8%	793	835	886	952	1,026	1,098	1,174	
Eligibles	2.3%	180,968	188,767	195,110	197,614	199,376	203,185	207,564	

Key Notes:

- Fixed federal contribution to be based on 52.51% FMAP in FFY2009; projected 54% beginning in 2010
- Forecast is based on historic trends with adjustments
- Federal fiscal year model
- Overall PMPM trend of 6.8% is highly consistent with CMS approved trends. For example, current year President's budget provides for up to 6.42% for children and families and 7.62% for persons with disabilities
- Anticipated program changes due to waiver not included in forecast
- Forecast is based on blended five year experience.

Financial Commitment: Federal Contribution

Submission to CMS						
Waiver Year	**WY1**	**WY2**	**WY 3**	**WY 4**	**WY 5**	**5 Yr Total**
	FFY2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013	
Total Dollars (millions)	$ 2,074	$ 2,257	$ 2,454	$ 2,677	$ 2,924	$ 12,386
Federal Contribution	$ 1,089	$ 1,219	$ 1,325	$ 1,446	$ 1,579	$ 6,658

Financial Commitment: State Contribution

Proposed Rhode Island ongoing financial commitment (Maintenance of Effort/MOE)

- Equal to percent of general revenue budget devoted to Medicaid in base year – SFY 2007
- Equals approximately 23% of general revenue budget
- Total state contribution indexed to growth in state general revenue

Global Waiver: Federal Flexibility

Eligibility, program & services that <u>remain the same</u> under Waiver:

- Federally mandated populations will continue to be eligible
- Federally mandated services will continued to be provided
- RIte Care managed care design will continue (health plan and services)
- Institutional care settings will remain an option for individuals with highest needs
- Care management programs (PACE, Rhody Health Partners, Connect Care Choice, RIte Care) will continue to be available

Global Waiver: Federal Flexibility

Eligibility, program & services <u>adjusted</u> under Waiver:

- Waiting lists for optional populations and services, if needed
- Cost-sharing for certain RIte Care populations (133% FPL and above)
- Mandatory enrollment of children with special health care needs into managed care (RIte Care)
- Long term care service options based on needs of individual
  - Mandatory enrollment in care management programs for adults with disabilities

Global Waiver: Federal Flexibility

Eligibility, program & services reformed under Waiver:

Eligibility:

- Coverage for three new populations
  - Parents with children in state custody who are pursuing behavioral health treatment for themselves with a goal of family reunification
  - Children needing residential mental health treatment. Currently parents must relinquish custody of their children to the State to become eligible for these services.
  - Elders at risk for long term care who could remain in their home if they received home and community based services.
- Income disregards for adults with disabilities living in the community, enabling adults to work without losing coverage
- Presumptive eligibility for individuals needing long term care

Global Waiver: Federal Flexibility

Eligibility, program & services reformed under Waiver:

Services:

- Assessment of individuals to determine long term care service needs
- Personal assistance budgets for individuals wanting to manage own care (self-directed care)
- Wraparound services enabling children to transition home from residential settings

Global Waiver: Federal Flexibility

Eligibility, program & services reformed under Waiver:

Delivery System:

- Rate adjustments for providers to enhance home and community-based system capacity
- Healthy Choice Accounts to provide incentives for healthy behaviors, use of primary care, and reduced use of emergency departments
- Selective contracting for certain services
- Quality assurance and improvement systems used consistently in provider settings

Medicaid Reform: Administration

Implementing and operating the Medicaid Program under the proposed Medicaid reforms will require a different business model

- Plan to centralize core Medicaid functions at OHHS, while population-specific program functions remain in OHHS departments
- Internal "capacity mapping" will commence in August
  - Bids received from experienced firms to assist OHHS to design and implement new business model. Final selection of firm by August 15.
  - "Capacity Mapping" will result in:
    - Assessment of current capacity to effectively implement and operate the waiver
    - Recommendations and description of a new business model for Medicaid, including skills, functions and organization
    - Opportunities to transition and reorganize current capacity to meet the needs of the new business model
    - Identification of additional skills, functions, and capacity needed

Global Waiver: Points to Negotiate

- List of federal rules asking to waive
- Waiver time period
- Extent of Federal funding
- Conditions defining the nature, character, and extent of Federal involvement and the State's condition for participation, including but not limited to:
  - General program requirements
  - Conditions defining CMS' and State's right to suspend or terminate Waiver agreement
  - Operational infrastructure assurances
  - State requirement to comply with APA
  - Reporting requirements – frequency and content
  - Covered benefits
  - Demonstration populations
  - Cost sharing
  - Delivery system conditions

Medicaid Reform: State's Role

All existing state rules, public processes, and safeguards remain in place

State role	Maintain existing processes…
Legislature	- Allocation of Medicaid budget - State laws governing Medicaid program elements for beneficiaries - State laws governing Medicaid payments to providers
Medicaid Agency	- Follow State laws - Grievance and appeals process - Rule-making process under Administrative Procedures Act for any changes under documented State Plan